The reimbursement rate paid to inpatient hospital care providers for the population described in 1902(a)(10)(A)(i)(VIII) of the Social Security Act shall be:

(a) Not less than the federal Medicare reimbursement rate for the service provided; or

(b) At a rate of 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

(c) Additionally:

a. Prescription drug coverage will be reimbursed at Medicaid rates or health plan contracted rates.

b. DSH, GME, and New Technology are add-ons and not payable.

c. Plans will apply Medicaid policy and pay the lower of billed charges or the Medicare allowed rate for hospital services.

d. Plans will apply Medicaid policy and deny applicable readmits following a previous admission and discharge for the same or related condition (as of this writing the readmission is defined as an admission within 3 days).

e. State will follow Medicaid policy and mandate observation rule. State will follow Medicaid policy and follow 23 hour outpatient billing requirements. Surgeries with less than 23 hour hospital stay when Medicare does not allow the procedure as an outpatient but Medicaid instructs <23 hours should be billed as OP. Example is ACDF surgery. This may require manual processing to pay at 130% of Medicaid rate.

f. Critical Access Hospitals (CAH) should be paid on DRG level- same as any other rural provider.